Letters

Infarctions were procedure-related (2). Furthermore, might have probably occurred in the IMPROVE-IT (2) subject to preference that falsely in coronary revascularization (an endpoint notoriously ezetimibe added to simvastatin was driven by both low-density lipoprotein cholesterol (LDL-C) with absolute benefits of 7 years, it has been shown that the truly enrolled in the IMPROVE-IT, with a follow-up in the PRECISE-IVUS trial (1). Outcomes: Vytorin Efficacy International Trial) (2)

### REFERENCES


### Evaluating Statin Versus Statin Plus Ezetimibe for Coronary Plaque Regression

Tsujita et al. (1) reported the results of the PRECISE-IVUS (Plaque Regression With Cholesterol Absorption Inhibitor or Synthesis Inhibitor Evaluated by Intravascular Ultrasound) trial which found that, compared with standard statin monotherapy, the combination of statin plus ezetimibe showed greater coronary plaque regression in a secondary prevention setting, and suggested that the clinical event risk reduction in the IMPROVE-IT (Improved Reduction of Outcomes: Vytorin Efficacy International Trial) (2) might have been derived from the suppression effect of coronary atherosclerotic development by dual lipid lowering therapy. However, after 12 months of follow-up in the PRECISE-IVUS trial (1) there have been no differences in clinical events between the two groups. Of note, in the similar population enrolled in the IMPROVE-IT (2), with a follow-up of 7 years, it has been shown that the truly significant event reductions, which led to the tiny absolute benefit in composite endpoint, of lowering low-density lipoprotein cholesterol (LDL-C) with ezetimibe added to simvastatin was driven by both coronary revascularization (an endpoint notoriously subject to preference that falsely inflates benefits) (3) and non-fatal myocardial infarction. Furthermore, it was not mentioned how many myocardial infarctions were procedure-related (2).

Indeed, loss of blinding to treatment allocation might have probably occurred in the IMPROVE-IT (2) because dual lipid-lowering therapy predictably greatly lowers LDL-C, and physicians who managed the patients knew the lipid variables (4). Loss of blinding might bias decisions about revascularization procedures and, in the ezetimibe plus statin group, loss of blinding could further result in fewer myocardial infarctions secondary to these procedures (5). The outcome least subject to bias is obviously all-cause mortality. In the IMPROVE-IT, the striking absence of benefit in reducing deaths from any cause, accompanied by the failure to reduce deaths from cardiovascular cause and from coronary heart disease in a high risk population, is worrying.

As practicing physicians, we would hesitate to prescribe an expensive therapy which may lead, at best, to few mm³ reduction in atheroma volume without meaningful reductions in clinical events.

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### REFERENCES


### REPLY: Evaluating Statin Versus Statin Plus Ezetimibe for Coronary Plaque Regression

We have read with great interest the letter by Drs. Mascitelli and Goldstein commenting on our recent paper (1), in which we showed that the combination of statin plus ezetimibe demonstrated greater coronary plaque regression compared with statin monotherapy. First of all, the PRECISE-IVUS (Plaque Regression With Cholesterol Absorption Inhibitor